2010 UBO/UBU Conference

Health Budgets & Financial Policy

Briefing: **Traumatic Brain Injury (TBI) Guidance**

Date: **24 March 2010**

Time: **1610–1700**

Objectives

- Define Traumatic Brain Injury (TBI)
- Coding instructions for Acute and History of TBI
- Late Effect Coding
- Post-concussive Syndrome
- Evaluation and Management and CPT/HCPCS Coding

TBI

- A traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:
  - Any period of loss of or a decreased level of consciousness;
  - Any loss of memory for events immediately before or after the injury;
  - Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.);
  - Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient;
  - Intracranial lesion

Mild TBI

- The majority of TBI is classified as mild.
- Mild TBI (also known as concussion or post-concussive syndrome) generally involves loss of consciousness last 30 minutes or less, post-traumatic amnesia less than 24 hours, and Glasgow Coma Scale of 13-15.
- Concussion can be graded according to loss of consciousness and amnesia.

Symptoms of TBI

- Poor concentration
- Irritability
- Fatigue
- Depression
- Memory problems
- Headaches
- Anxiety
- Trouble thinking
- Blurred or double vision
- Sensitivity to bright light
- Others: dizziness or vertigo, executive functions (processing, goal setting, planning organization, prioritizing, self-monitoring, problem solving, judgment), impulsivity, sensitivity to sound, tinnitus, decreases sense of smell/taste

Post Concussive Syndrome

- Personality change due to conditions classified elsewhere - cognitive conditions are coded as **310.1**
- Other specified non-psychotic mental disorders following organic brain damage - memory changes are coded as **310.8**
- **310.2 Post concussion Syndrome**
  - Excludes : frontal lobe syndrome (310.0) post-encephalitic syndrome (310.8) any organic psychotic conditions following head injury (293.0-294.0)

Post-Concussive Syndrome Definition

- **American Psychiatric Association** (DSM-IV) defined post-concussive syndrome (PCS) as:
  - History of TBI
  - Evidence from neurobehavioral testing of cognitive deficits in attention and/or memory
  - Three or more of the following symptoms that appear after injury and persist for three months or more: fatigue, sleep disturbance, headaches, vertigo or dizziness, irritability, apathy or affective disturbance, or personality changes
  - Symptoms in begin or worsen after injury;
  - Interference with social or occupational functioning;
  - Symptoms are not consistent with dementia and are not better explained by other mental disorders.
  - Symptom onset or course must be contiguous with TBI, distinguishable from pre-existing conditions, and of a minimum duration.

History of TBI Code Change

NOTE:

- Old Code: V15.59_X

  Code deleted from the DoD Extender List

  (Still listed in ICD-9-CM)

- New Code V15.52_X

  New Code in ICD-9-CM and added to DoD Extender List

In the MHS to track TBI occurrences we utilize the V15.52_x (history of TBI) along with the acute TBI codes, late effect codes, and/or symptomatology codes associated with a TBI.

Initial Coding Acute TBI/TBI Symptoms

- Initial TBI encounter the first listed diagnostic code (principal/primary) is the brain injury code
- Intracranial injury (e.g., concussion) usually entered very early in the triage or care process
- Injury code is not entered subsequently since repeated entries will skew TBI statistics
- If no TBI diagnosis, the DoD practitioner must make the diagnosis on the basis of available information as soon as it is manifested.
- The secondary code is the appropriate TBI V-code (V15.52_X).

TBI Coding

- Code all TBI cases within theater and at all military treatment facilities (MTF).
- TBI will be coded based upon documentation contained within the medical record and in accordance with MHS Coding Guidelines in Appendix G.
- **Code** Acute TBI if stated as possible, likely, or suspected TBI, for inpatient.
- V15.52_X would not be used with possible, likely, or suspected TBI on an inpatient.
- If TBI is confirmed prior to discharge, then code TBI diagnosis and V15.52_X.

Outpatient TBI

- Outpatients are never coded with probable diagnosis. V15.52_x should never be coded when there is an uncertain TBI diagnosis. In those instances where a patient is treated as an outpatient and the provider believes there is a possible, likely, or suspected TBI, outpatient coding rules require that diagnoses not be documented as "probable", "suspected," "questionable," "rule out," or other similar terms indicating uncertainty. Rather, the provider codes the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. This guidance differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

V15.59_X

- **Coding V15.52_x Extenders When Treatment is Reason for the Encounter.** TBI patients who receive inpatient or outpatient rehabilitation will be coded with the appropriate "V57.xx" code with a code for acute symptoms or late effects (905.0 or 907.0) being treated. The reason for the encounter (treatment) is always coded as the first-entered or principal/ primary diagnosis. A patient with a history of traumatic brain injury is coded with V15.52_x even if no residuals are present because such information may be relevant to care decisions.

Sequencing Codes

- **Sequencing of Codes.** When an individual has a confirmed or suspected TBI, the injury or primary symptom code is in the first field and the V15.52_x code is in the secondary diagnosis field:
- SIDR - position 2 – 20 on the standard inpatient data record
- SADR - position 2 – 4 on the standard ambulatory data record
- Ensure that any deployment codes and E codes appear in positions 3-4 in the SADR if they apply.

Subsequent Coding Acute TBI /TBI Symptoms

- Follow up visits, first listed diagnostic code (principal/primary) is the symptom that best represents the patient's chief complaint or symptom(s) (i.e., headache, insomnia, vertigo)
- If more than one symptom, code all symptoms that are present, that may influence health status, or are relevant to clinician decisions
- Exception to this rule, patients seen for rehabilitation, appropriate V-code (see V57.x) is the first-entered (principal/primary) diagnosis
- Few patients will meet the diagnostic criteria for post-concussion Syndrome (310.2); ensure the diagnostic criteria are met prior to using this code

Late Effects TBI

- Late effect is a residual effect (condition produced) after the acute phase of an illness or injury has terminated
- When acute phase is not defined and is left to clinical judgment
- No time limit on when a late effect code can be used
- residual may be apparent early, such as in CVA cases, or it may occur months or years later, such as that due to a previous injury
- Code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect

Late Effects TBI

- Coding of late effects requires three codes sequenced in the following order:
  - The condition or nature of the late effect is sequenced first.
  - The TBI V code is sequenced second, followed by the late effect code.

Acute and Late Effect

- **Guidance of Coding Acute and Persistent (Late Effect) Symptoms.** There is no accepted standard for when TBI symptoms cease to be acute and become persistent. The following guidance is recommended for documentation and coding consistency:
  - Acute—symptoms observed up to 7 days.
  - Sub-acute—symptoms observed 8-90 days.
  - Chronic—symptoms observed >90 days.

(Criteria consistent with DSM-IV)

TBI V15.52_x Extenders

- V15.52_x coding is mandatory. V15.52_x captures personal history of TBI. The code has been adapted for use in DoD to capture additional detail on nature of injury (penetrating and non-penetrating), severity of injury (e.g. loss of consciousness, post-traumatic amnesia, and Glasgow Coma Scale), and GWOT status. There are only five codes based on injury severity (mild, moderate, severe, penetrating and unknown). The V15.52_x extender code sequence repeats to capture GWOT, non-GWOT, and UNKNOWN if GWOT status. The New TBI V-codes became available 1 Oct 2010.

Coding

V15.52_X

- **Coding V15.52_x Extenders When Diagnosis is Certain.** If a patient has a confirmed injury to the brain, such as a penetrating head wound, concussion, and/or is suffering from post-concussion syndrome, then the V15.52_x extender code with the highest degree of certainty will be coded. Appropriate non-specific extenders will be assigned (e.g., V15.52_1, V15.52_6) when there is insufficient documentation to arrive a certain diagnosis.
- **Coding V15.52_x Extenders When Diagnosis is Uncertain.** Normally, this code is used to identify a personal history of injury with or without a confirmed diagnosis. Since DoD is using the code for a different purpose, the guidance herein differs from official ICD-9 guidance.

ICD-9-CM Acute TBI Codes

- 800-Fracture of vault of skull
- 801-Fracture of base of skull
- 803-Other and unspecified skull fractures
- 804-Multiple fractures involving skull or face with other bones
- 850-Concussion
- 851-Cerebral laceration and cojtusion
- 852-Subarachnoid, subdural, and extradural hemorrhage, following surgery
- 853-Other and unspecified Intracranial hemorrhage following injury
- 854-Intracranial injury of other and unspecified nature

Traumatic Brain Injury (TBI)

Coding

- **V15.52_0** Other
- **V15.52_1** Personal History of Traumatic Brain Injury (TBI), Global War on Terrorism (GWOT) Related, **Unknown** Level of Severity
- **V15.52_2** Personal History of TBI, GWOT Related, **Mild**
- **V15.52_3** Personal History of TBI, GWOT Related, **Moderate**
- **V15.52_4** Personal History of TBI, GWOT Related, **Severe**

Traumatic Brain Injury (TBI) Coding

- **V15.52_5** Related, **No** Level — Personal History of TBI, GWOT Penetrating Intracranial Wound, of Severity Assigned
- **V15.52_6** Related, — Personal History of TBI not GWOT **Unknown** Level of Severity
- **V15.52_7** Related, — Personal History of TBI not GWOT **Mild**
- **V15.52_8** Related, — Personal History of TBI not GWOT **Moderate**
- **V15.52_9** Related, — Personal History of TBI not GWOT **Severe**

Traumatic Brain Injury (TBI) Coding

- **V15.52_A** Personal History of TBI**, not GWOT** Related, Penetrating Intracranial Wound, **No** Level of Severity Assigned
- **V15.52_B** Personal History of TBI, Unknown if GWOT Related, **Unknown** Severity Level
- **V15.52_C** Personal History of TBI, Unknown if GWOT Related, **Mild**
- **V15.52_D** Personal History of TBI, Unknown if GWOT Related, **Moderate**
- **V15.52_E** Personal History of TBI, Unknown if GWOT Related, **Severe**
- **V15.52_F** Personal History of TBI, **Unknown if GWOT** Related, Penetrating Intracranial Wound, **No** Level of Severity Assigned

Health and Behavior Assessment/Intervention

- **Codes 96150–96155**
- Describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on biopsychosocial factors related to the patients health status.
- Do not represent preventive medicine counseling and risk factor reduction interventions.

(You are discouraged from using CPT code 96151 because this code cannot be used with an E/M)

Developmental Testing Codes

- **96110** Developmental testing; **limited** (Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report
- **96111** Developmental testing; **extended** (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report

CPT Coding

- **Education and Training for Patient Self Management (98960-98962)**
- Services prescribed by a physician and provided by a qualified non-physician healthcare professional.
- Designed to teach patients how to self-manage illness(es) or disease(s) effectively.
- May be reported when a standardized curriculum is used.

Example

- A soldier presents to the BAS after convoy hit by IED per CENTCOM policy. Other soldiers severely injured in same incident. Soldier denies LOC, but reports seeing stars, stumbling around for a few minutes, and he cannot account for approximately 15 minutes of activity after the explosion. At time of evaluation, soldier is asymptomatic and MACE score 30/30.
  - Primary diagnosis: 850.0 (Concussion without LOC)
  - Secondary diagnoses: V15.52_2 (Personal History of TBI, GWOT Related, Mild (Glasgow Coma Scale 13-15), LOC<1hr, Post Trauma Amnesia<24hr)
  - E979.2 (Terrorism Involving Other Explosions/Fragment
  - V70.5_5 (During deployment encounter)

Example

- A soldier presents to the MTF stating she is suffering from headaches which date back to an explosion occurring in Iraq two weeks ago. Provider reviews AHLTA notes and finds a note written immediately after the injury that document the injury event associated with an alteration of consciousness coded with 850.0. The provider determines that the complaints are acute.
  - Primary diagnosis: 784.0 (Headache)
  - Secondary diagnosis: V15.52_2 (Personal History of TBI, GWOT Related Mild (Glasgow Coma Scale 13-15), LOC<1hr, Post Trauma Amnesia<24hr)
  - V70.5_6 (Post-deployment encounter)

Note: V15.52_x associates the acute symptom (headache) with TBI.

Example

- A family member presents to the MTF clinic complaining of persistent headaches. Complains also of blurred vision, and dizziness (unspecified vertigo) since being involved in a motor vehicle accident with loss of consciousness for 15 minutes two months prior to this encounter. Review of previous AHLTA notes reveals an ER visit with a CT scan positive for frontal contusion and coded with 851.02 and V15.52_7. The encounter would be coded as follows:
  - Primary diagnosis: 784.0 (Headache)
  - Secondary diagnoses: V15.52_7 (Personal History of TBI, Not GWOT Related, Mild (Glasgow Coma Scale 13-15),LOC < 1 Hr, Post Trauma Amnesia < 24 Hr)

    907.0 (Late Effect of Intracranial Injury)

    368.8 (Blurred Vision)

    780.4 (Dizziness)

Example

- A soldier presents to the clinic for evaluation of persistent headaches after she answered yes to one of the TBI questions on the PDHA. Review of her AHLTA notes reveals post-MVC evaluation in theater with documentation of right arm fracture and facial contusions 6 months ago, but no documentation of TBI evaluation, no MACE, and no TBI diagnoses coded. Follow up visits indicate complaint of headaches, but no documentation of treatment. Patient interview reveals a history of headaches, tinnitus, intermittent dizziness, and blurred vision since the accident. She also had grogginess and poor recall of events for a few hours after the crash.
  - Primary diagnosis: 784.0 (Headache)
  - Secondary diagnoses: V15.52_2 (Personal History of TBI, GWOT Related, Mild (Glasgow Coma Scale 13-15), LOC<1hr, Post Trauma Amnesia<24hr)
  - V70.5_6 (Post deployment encounter)

Example

- A soldier presents to the MTF clinic three months after discharge. He complains of memory problems and slowed thinking, sleep disturbances, headaches, personality changes, and ringing in his ears. He has a history of a motor vehicle crash while deployed in Afghanistan where he struck his head on the steering wheel with loss of consciousness for ten minutes. The provider determines that the patient has cognitive deficits, headaches, personality changes, and tinnitus, and that these diagnoses are related to a TBI injury occurring during his deployment to Afghanistan and documented in his medical record as 850.11. The presentation conforms to criteria for post-concussion syndrome: (a) history of TBI; (b) evidence from neurobehavioral testing of cognitive deficits in attention and/or memory; (c) three or more of the following symptoms that appear after injury and persist for three months or more: fatigue, sleep disturbance, headaches, vertigo or dizziness, irritability, apathy or affective disturbance, or personality changes; (d) symptoms in (b) and (c) begin or worsen after injury; (e) interference with social or occupational functioning; and (f) symptoms are not consistent with dementia and are not better explained by other mental disorders. Symptom onset or course must be contiguous with TBI, distinguishable from pre-existing conditions, and of a minimum duration. The provider determined that this patient met the diagnostic criteria for post-concussion syndrome and documented the diagnosis as Post-concussion Syndrome. The encounter would be coded as follows:
  - Primary diagnosis: 310.2 (Post-concussion Syndrome)
  - Secondary diagnoses: V15.52_2 (Personal History of TBI, GWOT Related, Mild (Glasgow Coma Scale 13-15), LOC < 1Hr, Post Trauma Amnesia < 24 Hr)
  - V70.5_6 (Post-deployment encounter)

TBI

Note:

The UBU has work with subject matter experts to create TBI specific guidelines

Summary

- If not documented, it did not happen
- Vital for monitoring the deployment-related health concerns
- Coding/documenting are the only means for measuring outcomes
- Tools are available:
  - DoD Deployment Health Clinical Center website at: WWW.PDHealth.mil
  - UBU Website at: WWW.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm

Questions?

For questions on coding issues, please contact the Service Representative, as follows:

Army **https://pasba3.amedd.army.mil**

Air Force **https://phsohelpdesk.brooks.af.mil** or 1-800-298-0230

Navy **https://dataquality.med.navy.mil/reconcile/codinghotline/ticketentry.aspx**

(These Service sites can only be accessed from specific service domains (af.mil, navy.mil, army.mil) and must be CAC card enabled.)